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A 038	482.13 PATIENTS' RIGHTS A hospital must protect and promote the rights of each patient. This CONDITION is not met as evidenced by: Based on review of medical record, policies/procedures and Administrative Investigation Report (internal investigation) by facility; staff and client interviews; and observations, the facility failed to provide safe and appropriate restraint procedures for 1 of 1 patients. Findings include: Medical record review conducted on 10-31-06 revealed patient #1, a 43 year old male admitted on 9-29-06 to U2/3 East with a dx of Bipolar Disorder, Type I with Manic Exacerbations, was discharged on 10-12-06. Further review of medical record on 10-31-06 indicated restraint note statement: pt attempted to strike staff, medication give at 10:15am not effective. Staff #1, staff #2, staff #3 recorded (at 12:35pm) by staff #5 (documenter) injured pt #1-injuries to face, nose, head during NCI physical restraint. At 12:45pm psychiatrist #1 notified. Pt #1 reported assault and refused to talk until he could talk to police. Psychiatrist #1 note at 1:15pm: " Pt in NCI hold for 2 minutes and already released; pt upset but not threatening. " Further review of medical record on 10-31-06 indicated progress note by staff #1recorded at 12:50pm. Pt hit self; kicked staff #2 in groin; pt banging head on floor.	A 038		2/1/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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Further review of medical record on 10-31-06 recorded at 1:30pm indicated in nurse progress note. Pt attempted to hit peer. NCI hold 12:30 - 12:32pm; MD/PA notified.

Further review of medical record on 10-31-06 indicated at 2:00pm X-ray of ribs and facial bones ordered; placed on 1-1 supervision; medications ordered; ENT Clinic reports " assault with nasal fracture; painful to swallow. "

On 10-31-06 staff #20 interviewed concerning attached Administrative Investigation Report (AIR). The AIR is normally completed by Nursing and Pt Advocacy and same in this instance. Warrants were taken out by hospital against staff #1, #2 and #3. Pertinent staff listed by staff #20 with accompanying AIR responsibilities for this particular internal review. Staff #6 responsible for completing AIR; co-signed by staff #24 and staff # 26.

Review of Administrative Investigation Report on 10-31-06 indicated following interview of pt #1: " Patient stated that staff beat the hell out of him. The patient advised that he did know their names, however, he reported that the bald headed white guy wearing a gold chain, a patient that says he is a marine is a clean cut white guy, the guy wearing the Carolina ' s jersey with some blue in it is black guy and another tall black kind of big. There were four of them. The tall white guy brought me some cloths for me to change after my shower. They made me take a shower; they were trying to cover up what they did. They were stomping me in my Adam ' s apple. They were trying to kill me, I ' ll tell you. It happened around 12:30pm. It started because me and the marine were having a discussion about whose better than the Navy

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Seals. The staff here has been harassing me since I ' ve been here. They caught me unexpected, the white guy with gold chain, he grabbed me by my feet then they started carrying me down the hallway like you are going to the breeze way. The patient pointed to the nurse and stated he brought me the clothes (staff #8). Staff #8 denied bringing the patient any clothes. The patient reported that the staffs made him take a shower and would not give him any clean cloths until he took a shower. The patient stated that he kicked the white guy in the balls after acting like he was unconscious on the floor. (Note: A lineup was arranged in the interviewing room where the patient was sitting in front [of] the door and all the male staff working that day on that shift was asked to come to door of the interviewing room, the door was open and the staff members were instructed to state their names, position, and their assigned work areas. The patient gave a description of the patient and the patient was asked to be identified by the victim as well. The door was closed after each staff members and the patient provided the patient and interviewing team with their information.) Upon completion of the lineup the victim identified [staff #2] and stated he was the one he kick in the balls and also the one that grabbed his feet. The victim next identified [staff #1] and he expressed that he is the one that was stomping him. Then he identified [staff #3] replied that he kicked my ass and added that he was enjoying himself. The other guys started saying he was afraid. I asked for ice and they threw it on the floor. I had to clean up my own mess. They made me clean up my blood. They tried to make me formulate some story. Staff told me to tell I kicked him in the balls. I told them, I did kick you in the balls. "

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Review of personnel files on 10-31-06 of staff #1, #2, #3 indicated letters of dismissal dated 10-20-06 stated: " ....it is the determination of Management that dismissal from your position as a Health Care Technician I in the Adult and Acute Admissions Unit is the most appropriate action to be taken, effective October 20, 2006. Your behavior is considered Unacceptable Personal Conduct in accordance with State Personnel Manual, Section 7, page 3; specifically, conduct for which no reasonable person should expect to receive prior warning for and the abuse of a patient for whom you had a responsibility. "

Further review of staff #1 ' s personnel file on 10-31-06 indicated following documented problem behaviors in relation to abuse of pt #1: physical abuse of pt #0171800 on 10-31-06, struck pt #1 several times (witnessed by 2 HCTs), no report to RN of NCI hold; allowed pt to shower while bleeding profusely, no report of injury to RN, false and misleading statement during investigation, falsifying information on incident report and in medical record, exceeded scope of HCT practice by calling psychiatrist and requesting medication for pt, and refused polygraph.

Further review of staff #1 ' s personnel file on 10-31-06 indicated following written warnings: " grabbed pt and put hands on chest (5-12-06), placed pillow 6-8 inches from pt ' s face in order to keep him from spitting on anyone (3-15-06), refused to stay overtime (10-5-94). "

Review of staff #3 ' s personnel file on 10-31-06 indicated following problem behaviors in relation to abuse of pt #1: " inappropriate 2-man carry, no report of NCI hold to RN, no report of injury to RN, did not intervene or report coworker ' s

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abuse, false report and misleading evidence during investigation, failed to maintain confidentiality - talked to coworkers. "

Review of staff #2 ' s personnel file on 10-31-06 indicated following problem behaviors in relation to abuse of pt #1: " inappropriate NCI hold, excessive force during NCI hold (2 pressure points), no report of restraint procedures to RN, no report of injury to RN, no report of peer striking pt #1, and no report of pt bleeding profusely in shower. "

Interview was conducted on 10-31-06 of staff #21 in relation to up-to-date status of suspended employees. All 3 (staff #1, #2, #3) have been terminated - unacceptable personal conduct. They are barred from returning to campus except on official business; they must sign in at police office and sign out at police office if on campus. Each staff supervised by following: Staff #1 supervised by staff #6; staff #2 supervised by staff # 7; staff #3 supervised by staff #27. Broughton started working on new system for tracking staff who are potential pt abusers last summer. Surveyor referred to staff #22 who is coordinating the tracking system.

Interview was conducted of staff #22 on 10-31-06. Surveyor was referred to pt advocate (staff #24) who was responsible for working on Administrative Investigation Report for more detailed information. New tracking system is not in place but started working on last summer; more complicated than we expected. " We are working with Murdoch Center in effort to convert their system to our use at Cherry. " If we do not substantiate any wrongdoing by employee, nothing can be done formally. Follow up

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becomes a supervisory issue; there can be an increased level of supervision, monitoring work with pts more closely, and additional training. The new program from Murdoch Center will assist us in aggregating the information on potential pt abusers. " We want a system that identifies staff who are consistently involved in HCPR reports. This new system will be turned over to management (i.e. Nursing) when fully installed. " The development of the new system is being coordinated by Pt Advocacy and will be turned over to the Nursing Dept when completed.

Further interview of staff #22 on 10-31-06 indicated HR ' s role in working on this issue is limited because they cannot get involved unless formal disciplinary action has been taken against employee. This is based on State Personnel Act and not on a local preference. HR may not know of HCPR reports because of this.

Further interview of staff #22 on 10-31-06 indicated the Patient Advocacy Department ' s role in personnel issues is limited to assisting in establishing a system to track potential abusive employees in conjunction with Nursing; then will be turned over to Nursing when in place. Further responsibilities are observing on job and helping train employees, making recommendations to Management/Nursing, making recommendations to add topics to orientation and on-going training.

Further interview of staff #22 on 10-31-06 indicated following reasons for calling in police: when staff accused of sexually abusive behavior; Nursing, Pt Advocacy Department, and Hospital Director can call in police; and pt can request police.

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Review was conducted on 10-31-06 of Pt Advocacy Department ' s file on incident. Reviewed Administrative Investigation Report (18 of 18 pages including content of full investigation and 3 HCPR reports), Investigation Tracking form (3 0f 3 pages), Preliminary Report of Alleged Abuse, Neglect or Exploration of Patient, 3 letters of investigatory leave dated October 3, 2006, 3 warrants taken out by Cherry Campus Police, and color pictures of injuries to pt #1. (Did not copy pictures because did not think injuries would show up in black and white.)

Staff #23 was interviewed on 10-31-06. Suggestion made to contact 3 terminated staff by phone at home and make interview arrangements. " It is rare for Cherry to terminate employees. " There is code of silence - therefore - no witnesses.

On 10-31-06 staff #6 was interviewed. During incident RNs were in office and staff #6 was in my office downstairs. Staff #6 was contacted by staff #24 and indicated that Psychiatrist #1 had been contacted concerning allegation of pt abuse. Staff #6 and #24 went to unit and asked for Psychiatrist #1 but he was in conference with police and pt #1. Hospital Director, _____, and staff #26 came in. Pt #1 said 3 HCTs beat him. They took him down, dragged and beat him down the hall. Doors to hall were closed. Pt #1 stated he kicked him in the balls. HCTs told pt #1 had to clean up his mess (i.e. blood) and they discussed with pt #1 what to say had happened. Pt #2 was asked by HCTs to help make up a story to tell. Pt #1 stated his nose and mouth were bleeding. He was asked to take shower and get clean clothes. RNs saw pt #1 in shower. Pt #1 then identified which HCTs were

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involved. Staff #6 and other staff asked 3 HCTs to leave building and told them they were on investigative leave.

On 10-31-06 staff #4 was interviewed. Don ' t always feel safe at work because " HCTs say if you don ' t cover us, we won ' t protect you from patients. Psychiatrist #1 does not give enough meds to help us from pt abuse. I was told about NCI hold. Two RNs got papers out and went to pt #1 ' s room. He was in shower. We followed him to his room. We felt something bad had happened. We assessed. PA was told of serious of incident and he came. Pt was sent to X-ray. There is a culture. We RNs need to meet and do something about the HCTs running the place. Pt #1 stated this had been planned - that HCTs were watching for the opportunity to get him. " Staff #4 has no knowledge of internal investigation.

On 10-31-06 staff #7 was interviewed. This employee not familiar with incident. Staff #3 was not under investigation so should have been able to work in 3E. He was not banned from this unit. " I never had a hint that assault was planned. "

On 10-31-06 staff #8 was interviewed. This staff feels safe on units but maybe would not if female. Staff has heard of " I won ' t cover you " issue: If HCTs are given a hard time by RNs, the HCTs will not protect them from patients. " HCTs called me in my office and asked can you come up here? I went, they were down hall. 2 pts fought, staff #2 separated them and staff #2 got kicked. Took pt #1 down - pt #1 got hurt. I went to bathroom - he was at mirror, he wouldn ' t talk to me. I went to station told staff to call PA/MD and start paperwork. Psychiatrist #1 came. He saw pt#1 and called police. "

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On 10-31-06 staff #24 was interviewed. Little after 1:00 pm on October 3, 2006 this staff called by Psychiatrist #1; told obvious that pt #1 had been abused. Pt #1will not talk to anyone but police. Hosp Dir, 2 police officers, staff #24, staff #6 and staff #26 arrived on-site. Hosp Dir did line up one by one and pt #1 identified staff #1, #2, #3. 3 staff immediately separated so " could not get story straight; got 3 totally different stories. " By rule must be at least 1 RN on unit at all times. Both were off unit when incident occurred. Staff #3 reiterated 3 different versions of events. Internal investigators were told during interviews that staff didn ' t have time to apply NCI holds appropriately. None of injuries were inflicted by pt. Staff #3 applied pressure points during " restraints " of pt #1. Some evidence that an unnamed employee " covered " for 3 terminated staff by sending Psychiatrist #1 to cafeteria when he knew staff were not there - possibly to give 3 terminated staff time to " cover up " the incident.

Further interview of staff #24 on 10-31-06 indicated no policy as to when police are contacted when incidents occur at hospital. Police contacted based on " verbal protocol " ; always called in when pt requests. When constant HCPR unsubstantiated reports on same staff nothing is done. " Only good thing to come out of this - since the incident on October 3, no incidents from that unit have been reported. "

Staff #25 was interviewed on 11-1-06. " We got call about pt allegations against staff for assault. I sent officer over with a camera. When he saw pt he called me. " Talked to pt #1 who said " 3 staff and another pt had beat him " . Pt identified all 3 staff. Pt ' s blood pressure was checked and

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he was given ice pack. 3 accused staff were immediately taken to police department. There was no evidence of pre-meditation. Staff #25 was told that it all started with staff trying to block a punch pt #1 threw at another pt. " Pt #1was taken down by staff #2 who admitted using pressure points " . No evidence that any other pt was involved in alleged abuse. Police told that pt #1 was taken down hall. Staff #2, #3 stated pt #1 was calm. Staff #2, #3 stated staff #1came in room and started slapping pt #1 with open hand. Staff #1 denied hitting pt. This interviewee has no knowledge of previous histories of staff involved.

Further interview of staff #25 on 11-1-06 revealed police always supported by Cherry Administration. 90% of calls are for pt to pt assault. Staff #25 was not aware of any written policies/procedures on when and when not to contact police.

Second interview of staff #21 was conducted on 11-1-06. HR allowed to become involved only when disciplinary action taken. HR not allowed to take any kind of action on unsubstantiated HCPR allegation; can take action on HCPR allegation only if substantiated.

Surveyor chose 10 HCTs and HCPR office reviewed their files to ascertain if any had substantial number of reported allegations - to see if Cherry had taken any action on unsubstantiated HCPR allegations. One (HCPR #1) did have 11 unsubstantiated allegations. (This information was to be presented to staff at Cherry to ascertain if any special action has been taken to assist this employee in improving and to attempt to prevent potential pt abuse.)

Second interview of staff #22 was conducted on

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11-1-06. Any staff suspected of pt abuse or potential pt abuse is handled on one by one basis. Primarily the responsibility of Nursing but assisted by Pt Advocacy Dept. Pt Advocacy Dept is coordinating work on the development of computer program to track potential abusive staff by name, by shift, by time of day to identify specific staffing and/or specific staff problems. " We are re-writing policies/procedures on abuse/neglect; should be operational by January 1, 2007. "

On 11-2-06 surveyor observed on unit where incident occurred (U2 3East). During observation no out of ordinary problems were experienced and unit was fully staffed during observation.

An interview of staff #28 was conducted on 11-2-06. The same staff investigates allegations of abuse by staff of patients: nurse managers and pt advocates. If the allegations are unsubstantiated and there are " many unsubstantiated allegations " there are plans of correction. Example would be retraining.

An interview of staff #29 was conducted on 11-2-06. New training module called " Mental Illness: Sensitivity Training " started on 9-6-06 instituted by Hosp Dir. This new training includes characteristics/symptoms of mental illness; how to interact with the mentally ill patient; how to de-escalate inappropriate behaviors. All new staff have taken this course and " older " staff will take in future.

The personnel file of staff #10 was reviewed on 11-2-06. All training including NCI was up to date.

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The personnel file of staff #11 was reviewed on 11-2-06. All training including NCI was up to date.

The personnel file of staff #12 was reviewed on 11-2-06. All training including NCI was up to date.

The personnel file of staff #13 was reviewed on 11-2-06. All training including NCI was up to date. Two unsubstantiated Nurses Aid I allegations included in file.

The personnel file of staff #14 was reviewed on 11-2-06. All training including NCI was up to date. This employee was terminated on 8-19-04 for unacceptable conduct and reinstated on 8-20-04. Unacceptable conduct was alleged (i.e. physical abuse) but peers " did not see " and verbal abuse of pt witnessed by pt advocate. There were additional written warnings for restraint w/o de-escalating behavior, improper restraint, and verbally abusive to pt, sleeping on the job. There were 2 NA I unsubstantiated allegations. He was retrained in NCI and attended Therapeutic Communication training. Staff was referred by HR to EAP.

The personnel file of staff #15 was reviewed on 11-2-06. Employee was reported to NA I registry on 2 occasions; both unsubstantiated. All training of employee was up to date including NCI.

The personnel file of staff #16 was reviewed on 11-2-06. All staff training was up to date including NCI.

The personnel file of staff #17 was reviewed on 11-2-06. All staff training was up to date including

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A 038	Continued From page 12 NCI The personnel file of staff #18 was reviewed on 11-2-06. Staff had one week suspension w/o pay on 6-9-05 for inappropriate communication with pt, admitted abusive language with pt, refused to leave when requested by supervisor. Staff completed Therapeutic Communication training. The personnel file of staff #19 was reviewed on 11-2-06. There was one NA I unsubstantiated allegation. All training was up to date including NCI. Staff #26 was interviewed on 11-2-06. Staff summarized procedures for dealing with potential pt abusers. Every Monday morning a team, consisting of Hosp Dir, Dir of Nursing, Pt Advocacy Dir and other pertinent staff, meet to discuss any " open cases in nursing and/or pt advocacy. " We want to get better. Where there is smoke there is fire is the attitude. We want to track repeat offenders. " All HCPR allegations are reviewed as part of this process. The following actions re to an employee may be taken: disciplinary action, additional training, re-assignment of staff, closer monitoring of staff, supervisory conference. In some cases after all information is in, the nurse managers make recommendations to the DON. HR does not get involved unless there is official disciplinary taken, but they do confer with us and assist with recommendations. Final decisions are made by the DON. Further interviewing of staff #26 indicated staff #1 was on the " radar screen " . He had been required and had completed NCI training and the Therapeutic Communication training. Staff #2	A 038		

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and #3 were not being followed.

Interview of staff #2 was completed on 11-2-06. " Staff #3 and I went to work on 3 East. Pt #1 was cutting up; upsetting whole ward; threatening other pts; trying to get me with a pencil. Psychiatrist #1 was phoned by staff #1to tell him pt #1 threatening people. " Psy #1 reported that he would be there later; he had 2 admissions he was doing and could not get to unit immediately. " Doc arrived around 11:45 - 12:00. Pt #1asked Doc for meds but he did not give. This is what happens when Docs don ' t give enough meds. "

Further interview of staff #2 on 11-2-06 revealed pt #1 got into altercation with another pt; tried to hit him. Staff #2 blocked the punch and then " took him down. I didn ' t do proper NCI hold after I got kicked in the groin. I hit his head on a chair. I was on his head and staff #3 on his feet. I did pressure point to his clavicle because he was not calming down. All pts were upset and no nurses on unit. "

Further interview of staff #2 on 11-2-06 indicated pt taken down hall by staff #2 and #3 to his bedroom. " You need to go to your room. Pt pushed staff #2 up against wall and kicked staff #3 in the chest. I did pressure point on chest and he fell back on floor. We got to the doorway of pt ' s bedroom and staff #1 came in and started hitting pt #1with his open hand. Staff #1 slapped him at least twice and blood went everywhere. I know I did not do right NCI hold but I got kicked in the groin area. I know I was wrong. I wanted to put him in his bed until Doc got there. If I had to do over I would mash button but have seen what happens when a lot of people come from other wards. Didn ' t want all that commotion. Not sure

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if I had front or feet. I don ' t know how pt got the shoe marks. Don ' t know how this happened. Don ' t know why staff #1 slapped him. I did not kick him - didn ' t beat him like papers and everyone says. "

Further interview of staff #2 on 11-2-06 revealed statement: " I told pt hate what happened to you and was helping him out. Pt said where are my meds? Ready to see him (i.e. ready to see Psy #1). I told Psy #1 pt got hurt. He asked what happened? Pt told Psy #1 I was slapped in face. Psy #1 said you ' re all going down for this. We cleaned up blood but not to get rid of evidence but because it was our job. I ' m guilty of neglect; should not have let this happen and should have mashed my button. Should not have this thrown back at me. We told the truth and this is where it got us. Should have gotten demoted but not fired. It falls on Doc because he did not take care of pt and then it falls back on us. "

Further interview of staff #2 indicated that he feels building containing this unit is unsafe and staff do not want to work there. " I didn ' t want to work on 3 East because its unsafe. No supervision up there. I ' m just HCT, a little ant. After this I hope people will know. Nursing and Docs can ' t run hospital w/o HCTs. Don ' t think good of us. All kinds of things happen but nobody listens to us. Got to start listening to little Indians. Got to start from bottom; can ' t start in middle. Docs and nurses get by with doing anything. So do higher ups. I feel like a certified dumb ass. I am going to take this as far as I can after this is over. "

Staff #1 was interviewed on 11-2-06. " Day shift started at 7:00am. Pt #1 was agitated; informed nurse; wrote notes. He acted like he was manic.

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Put in movie but pt #1 got in front of TV and turned it off and said you got to call me Mr. _____, get respect. Threatening staff and pts. Doc called but doing something else. He did come, but he didn ' t have time and he left. Pt agitated all this time. " When staff #1 arrived back on unit from taking trays to dining room, he saw HCTs on the floor. " By the time I got there his face was bloody. I asked how all blood happened and they (staff #2 and #3) said he hit himself. Put him in the shower. When I arrived pt was already in the shower. While in shower everybody came in. Psy #1 went and got everybody. Pt saying we beat him up. " Interviewee could not account for shoe marks on body of pt #1. Indicated he did not know exactly where pt #1 ' s bedroom is.

Further interview of staff #1 was conducted on 11-2-06. " Been here over X years. Past several years in U2. Makes me feel good when everybody does job. Docs don ' t medicate pts enough to get well. Psy #1 has kept pts here 3-4 months on low meds. Don ' t get better. Puts HCTs in bad spot. Don ' t know if Administration doesn ' t see this or what. Throw policies at us everyday w/o inservice. Can ' t run a hospital like that. Dealing with people not manufactured parts. Always looking at HCT. We have competent HCTs. Lots of stuff needs to be changed. Hosp Dir getting rid of good people w/o looking further. Stood in U2 and told us some would not be here in a month. Decreased morale. Feel like I have been singled out on TV and radio; tx like a criminal. My picture was only one on TV. I have been singled out and I wasn ' t even there when pt abused. "

Policies and procedures relating to - when to

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A 038	Continued From page 16 contact police re an investigation - were reviewed on 11-2-06. The p/p state police are responsible for getting involved in following: sexual misconduct, search and seizure, abduction, abuse/neglect/exploration, and escape. Staff #26 was unable to list all these. He stated " We get involved when we get a phone call. " Staff # 26 was interviewed a second time on 11-2-06. The DON is responsible for sending reports to HCPR. Surveyor indicated to staff #26 that had randomly selected 10 staff chosen form HCT employees at Cherry and located one staff member that may need to be flagged for potential pt abuse because of number of unsubstantiated HCPR allegations. Records and supervisor were checked but nothing official being done with this employee at this point because nothing has been substantiated. Further investigation of staff #26 on 11-2-06 indicated new training program currently being implemented includes: mental illness " sensitivity " training, therapeutic communication, and cultural diversity. Also the abuse/neglect/exploration procedures are being revised.	A 038		